

# Forensic care pathways for adults with intellectual disability involved with the criminal justice system

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# Foreword

This Faculty Report sets out how people with intellectual disability can interact with the criminal justice system. This is of crucial importance to people with intellectual disability, who may encounter difficulties and a lack of understanding about their needs at different stages of the criminal justice process. Many people they encounter will not have specialist expertise in supporting people with intellectual disability, but this report really helps to enable non-specialists to have a better understanding of the needs of this vulnerable patient group and how they can best support them, including when community options are appropriate and when to get more specialist services involved. It also makes clear recommendations about how, for example, the police and prison services can develop skills by including information about people with intellectual disability in induction programmes.

Good commissioning of specialist forensic services for people with intellectual disability is essential, especially in the light of the poor practice exposed at Winterbourne View hospital and the relative lack of monitoring by commissioners and regulatory bodies. Often commissioners may have to take up a brief at short notice, so this report will be invaluable to them. It is essential that there is proper strategic commissioning, especially for services working with prisoners, and to ensure there is a proper range of secure in-patient services so that those who require in-patient treatment can be treated in the least restrictive setting and as close to home as possible.

The report also makes clear that proper outcome-based research is required, including an economic analysis, to ensure that we make the optimum use of resources to provide services that give the best chance for people with intellectual disability to successfully address their offending behaviour.

*Dr Ian Hall  
Chair of the Faculty of Psychiatry of Intellectual Disability  
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# Preface

This document aims to highlight good practice guidelines for pathways of care for people with intellectual disability involved in the criminal justice system.

Its objective is a description of a care pathway that involves the criminal justice system (including police, courts, prisons and probation), specialist intellectual disability services, adult mental health services, forensic services and Social Services in England and Wales. It identifies the key roles and responsibilities of professional input (including triggers of involvement) and provides good practice guidance on multi-agency and holistic approaches in the management of offenders with intellectual disability.

Although the report touches on specific subgroups (e.g. people with autism spectrum disorder, women, children, adolescents and people with sensory impairments), there are no specific chapters on these areas, and readers are advised to seek specialist advice in those fields.

All chapters in this document end with key recommendations to relevant stakeholders.

The target audience is psychiatrists, psychologists, nurses and allied health professionals working in specialist intellectual disability, forensic mental health, and adult mental health services. This report is also highly relevant to commissioners (health and local authority) and criminal justice system professionals.

This document was drafted by a joint working group of nine members drawn from the Faculties of Forensic Psychiatry and Psychiatry of Intellectual Disability of the Royal College of Psychiatrists. The final version, including recommendations, emerged after discussions with a wider consultative group and we thank all those who contributed to this effort.

We are very grateful to Ms Verity Chester, research assistant to Dr Regi T. Alexander, for her help with the relevant literature searches.

*Dr Regi T. Alexander  
Editor of the joint working group*

*Dr Harm Boer  
Chair of the joint working group*



# Executive summary and recommendations

This document has been produced by members of the Faculties of Psychiatry of Intellectual Disability and Forensic Psychiatry of the Royal College of Psychiatrists. It describes the key stages of the care pathway for people with intellectual disability who have been charged with committing, or are suspected to have committed, offences.

There is some confusion as to whether people with intellectual disability who offend should be dealt with by health or criminal justice systems (or both). A failure to report, and therefore to prosecute, episodes of serious challenging behaviour may lead to an individual believing that such behaviour is acceptable, leading to further and potentially more serious acts. However, an assumption that forensic psychiatry services offer the way forward for everyone with an intellectual disability and offending behaviour could also be potentially reductionist and simplistic. Whether these patients access services through forensic services or through 'non-forensic' community and hospital services, what is most important is that their needs are identified in a timely manner and that they receive the appropriate therapeutic input.

When people with intellectual disability do access the criminal justice system there are significant dangers that their specific needs will not be recognised and therefore not met. Even when professionals within the criminal justice system do recognise a person's intellectual disability, they may not be aware of their statutory responsibilities or of how to access appropriate support services. Intellectual disability services in turn frequently lack knowledge of the criminal justice system and, in contrast to mental health services, are rarely party to local health and criminal justice policy and service planning.

There is a larger group of offenders with learning difficulties (as opposed to intellectual disability) who may be less visible but are, nonetheless, vulnerable. In contrast to individuals with intellectual disability, there will often be no statutory services designated to address their specific needs.

Intellectual disability services have rarely been party to the increasing collaborative arrangements between mental health and criminal justice services; therefore 'diversion' between specialist intellectual disability and criminal justice services may represent an offloading of an individual with complex problems rather than an opportunity for collaborative working between partner agencies.

Professionals, particularly those with no knowledge, experience or expertise in working with people with intellectual disability, can sometimes express the view that nothing can be done under the Mental Health Act 1983 because the person is not 'mentally ill'. It is important for professionals to

be aware that intellectual disability associated with abnormally aggressive or seriously irresponsible behaviour could potentially be a mental disorder, even if the person does not have a mental illness, and that a referral to psychiatric services for people with intellectual disability may be appropriate. In addition, many people with intellectual disability may have other mental health problems. In police stations, appropriate adults (National Appropriate Adult Network, 2001) and medical opinions should be sought.

All courts need access to a court diversion scheme that has links with people experienced in assessing people with intellectual disability. Psychiatric trainees gaining a Certificate of Completion of Training (CCT) in intellectual disability psychiatry should be competent in applying those parts of mental health legislation relating to people concerned in criminal proceedings and in providing reports to the court. Psychiatric reports for the court on people with intellectual disability should routinely contain recommendations to the court on necessary adaptations to the court process. In order for some accused people to have a fair trial, the Witness Intermediary Scheme should be available to vulnerable defendants.

There is a balance to be struck between diverting people with intellectual disability and significant mental health problems from the criminal justice system and those factors favouring prosecution and safeguarding the public. Wherever possible, the aim is to maximise the use of community disposals. A large range of community disposals are open to courts at the sentencing stage. Ongoing specialist professional support is crucial to the implementation and success of these community disposals.

Courts, probation services and youth offending teams in each locality should have access to intellectual disability services as a first point of contact. This should ideally be a dedicated community forensic intellectual disability team, of which there are a few examples. If that is not available, the function can be carried out by a community intellectual disability team or, depending on local protocols, an appropriately skilled mainstream mental health or forensic mental health team.

Protocols for joint working between community forensic intellectual disability, community intellectual disability, community forensic and community mental health teams should be developed locally and opportunities for pooling resources and sharing skills should be explored. Community intellectual disability teams and professionals need structured training on risk and related forensic issues, whereas those from mainstream mental health or forensic services need training in intellectual disability.

There is still a limited understanding of the prevalence and needs of people with intellectual disability in prisons, who probably receive insufficient support and treatment. They are likely to experience greater difficulty coping in custody and to be vulnerable to bullying, and they are less likely to participate in or benefit from prison treatment programmes.

It is estimated that there are about 48 high, 604 medium and 1741 low secure beds in addition to 345 forensic rehabilitation beds for people with intellectual disability in England. These are very unevenly distributed, causing some people to be placed far away from home. These units treat a group of people with intellectual disability and very high rates of comorbidity including personality disorder, substance misuse, autism spectrum and other developmental disorders.

The nature of treatments available in secure units for intellectual disability has not been described precisely, although there are some broad frameworks that are now available. There is a paucity of outcome studies in this area and none examining costs.

## RECOMMENDATIONS

- 1 There should be national standards on health and social care provision for offenders with intellectual disability, with clear lines of accountability and explicit mechanisms for addressing any apparent gaps in service provision. Particular attention should be paid to the commissioning of a range of in-patient and community services that will allow people with intellectual disability who offend to be managed safely in the least restrictive setting.
- 2 There also needs to be greater clarity in the use of terminology (e.g. intellectual or learning disability, learning difficulties, etc.) both within and between health, social care and criminal justice systems.
- 3 Local multi-agency strategic planning groups must be developed between intellectual disability and criminal justice services, with the aim of preventing offending and reoffending. These do not necessarily need to be distinct from existing mental health arrangements, but must include specific arrangements for joint training and collaborative working in relation to people with intellectual disability.
- 4 All police officers, in particular custody officers and community support officers, need to have intellectual disability awareness training as part of their induction process. This training should be provided with input from health professionals.
- 5 Custody suite staff should be able to recognise whether someone has intellectual disability and know who to contact about this in order to ensure the person receives the necessary support.
- 6 Appropriate adults should follow the same individual throughout their contact with the criminal justice system to ensure continuity for the detainee.
- 7 There needs to be an identified link police officer at every police station who should attend the police liaison group which occurs with the local health service, and work collaboratively with local mental health and intellectual disability services. Good links with the local community support team must be available, so that they can access advice, assessment, treatment, court reports and joint work for individuals in their service, and also more general advice and training in intellectual disability.
- 8 People with intellectual disability should have equitable legal and civil rights to other people. Those who are at risk of offending should also have a right to be held accountable for intentional actions, to have fair boundaries set and to have the full range of sentencing options available to them, if convicted. In view of their vulnerability and limited understanding, they may have difficulty in exercising their rights within the criminal justice system. Consequently, they may need support when they enter the criminal justice system.
- 9 All courts should have access to a court diversion scheme and all such schemes should have input from health professionals trained to work with people with intellectual disability.
- 10 Members of the judiciary and the probation service should be trained in mental health and intellectual disability awareness.

- 11 Psychiatric reports on people with intellectual disability for the courts should be provided by professionals who are both experienced in working with this group and appropriately trained to provide advice to the courts.
- 12 Psychiatrists and trainees gaining a specialist qualification in intellectual disability psychiatry should be competent in applying those parts of the relevant mental health legislation relating to this population and should be competent in preparing a psychiatric report for the court, particularly in the areas of fitness to plead and appropriate disposal options (how the court deals with the case).
- 13 Psychiatrists and trainees gaining a specialist qualification in intellectual disability psychiatry should be fully aware of the provisions of the criminal justice system with regard to the provisions for vulnerable defendants, including knowledge of appropriate disposal options if found guilty.
- 14 Psychiatrists and trainees gaining a specialist qualification in forensic psychiatry should ideally have obtained some experience in working with offenders with intellectual disability and competencies should be identified with regard to this.
- 15 Psychiatric reports on people with intellectual disability for the court should routinely contain recommendations to the court on necessary adaptations to the court process.
- 16 Courts, probation services and youth offending teams in each locality should have access to intellectual disability services as a first point of contact. This should ideally be a dedicated community forensic intellectual disability team or a specialist function within the intellectual disability team. If that is not available, the function can be carried out by a community intellectual disability team. Depending on local protocols, this function may also be carried out by mainstream mental health or forensic mental teams provided they have the appropriate skills.
- 17 Protocols for joint working between community forensic intellectual disability, community intellectual disability, community forensic and community mental health teams should be developed locally and opportunities for pooling resources/sharing skills should be explored. Local pathways should be developed in conjunction with other agencies involved in the management of an offender with intellectual disability.
- 18 Community intellectual disability teams should receive further training to manage less serious offending and to provide input where specific community forensic intellectual disability teams are not feasible or where the case-load demands it. Likewise, in areas where they carry out this function, community forensic and mental health services will need training on issues of intellectual disability.
- 19 Training of the members of the intellectual disability teams could include input from psychiatry, nursing and psychology, with the team accepting referrals from existing National Health Service (NHS) services and the criminal justice system. The team should provide expertise to the criminal justice system and make recommendations for community disposals where appropriate.

- 20 In order to recommend community disposals, the appropriate treatments should be available (from community forensic intellectual disability teams or from specialists within generic intellectual disability teams) in the form of adapted programmes for substances misuse, sex offender treatment, fire-setting and violent offending; preferably in collaboration with mainstream services as outlined in *Valuing People* (Department of Health, 2001). Such programmes may need to be flexible so as to not exclude those with borderline intellectual disability.
- 21 Based on existing Department of Health work, all prisons in England and Wales should include proper and full reception screening for intellectual disability as part of routine screening procedures (currently done in accordance with the Grubin tool; Grubin *et al*, 2002). As mentioned in 'The criminal justice system', the recently developed Learning Disability Screening Questionnaire (LDSQ) can be a suitable tool ([www.gcmrecords.co.uk/gcm\\_records\\_007.htm](http://www.gcmrecords.co.uk/gcm_records_007.htm)).
- 22 All prison healthcare providers should work with local community intellectual disability service providers to assist in ensuring that local team expertise is incorporated within the prison. This could, for example, involve visiting sessions from an intellectual disability/dually trained psychiatrist or regular attendance by a community psychiatric nurse who has training in intellectual disability.
- 23 In order for such services to work, they will require full integration with existing prison mental health services (including primary care services) to ensure joint working, learning from experience and education.
- 24 Intellectual disability referral pathways need to be clearly mapped in agreement with local intellectual disability services, with the following questions in mind, and recognising that most individuals can be supported within the prison system:
  - a Who should be referred?
  - b When should they be referred?
  - c What response can be expected following referral?
- 25 Local initiatives in respect of joint working with other agencies (including the voluntary service) should be encouraged. Commissioners of services should be integral to this process.
- 26 Inside prisons, joint working between existing mental health providers, primary care and other multi-agency partners is recommended. This may require a joint vehicle for the discussion of complex cases, and arranging a meeting to determine which agencies should be involved in each particular case is recommended. This meeting will resemble an 'internal' Multi-Agency Public Protection Arrangements (MAPPA) meeting, but, unlike MAPPA, will not be restricted to high-risk individuals.
- 27 Particular attention should be paid to the commissioning of a range of in-patient and community services that will allow these patients to be managed safely in the least restrictive setting. Offenders with intellectual disability should be treated as near as possible to their home area.
- 28 Reliable data on the number of offenders with intellectual disability in secure units should continue to be actively collected.

- 29 The nature of treatments offered should be clearly described and a common data-set of short-term and long-term outcome variables collected through a nationwide audit. This should include information about the cost of placements. Such information should be used to identify predictors of length of hospital stay and successful treatment outcomes.

# Intellectual disability and offending behaviour

## INTELLECTUAL (LEARNING) DISABILITY V. LEARNING DIFFICULTIES

By definition, the term intellectual disability or learning disability refers to a person with:

- significant impairment of intellectual functioning (IQ <70 on an established IQ test such as the Wechsler Adult Intelligence Scale, WAIS-IV; Wechsler, 2008)
- significant impairment of social functioning (there is no gold standard test to measure this at present; clinicians tend to use adaptive behaviour assessment scales such as the Vineland Adaptive Behavior Scales (Sparrow *et al*, 1984) or the Adaptive Behavior Assessment System (Harrison & Oakland, 2003))
- significant impairment which has been present from childhood (onset during the developmental period).

In contrast, the term learning difficulties (used by the UK Department for Education) can cover a range of conditions including specific learning disabilities or dyslexia, dyspraxia, speech, language and communication problems, sensory impairments, attention-deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD) as well as individuals functioning in the borderlines between normal and impaired intellectual functioning. In the recent past there have been other definitions such as that provided by the Mental Health Act 1983 for 'mental impairment' under the definition of 'Mental Disorders': some patients detained under these categories did not have intellectual disability in the stricter sense but were more likely to have had borderline intellectual functioning. Even in the strictest possible definition, people with intellectual disability are a heterogeneous group with different degrees of ability, comorbidities and other confounding factors including those relating to communication, sensory impairments, mobility and other health problems.

Inconsistent application of definitions and terminology – especially between intellectual disability, learning disability and learning difficulties – has led to considerable confusion in both research and clinical practice. The category of borderline intellectual functioning becomes relevant here and is defined in DSM-IV-TR (American Psychiatric Association, 2000) as an IQ range of between one and two standard deviations below the mean (70–84). Using this definition, 12.3% of a UK-wide cross-sectional sample of 8450 adults living in private households have borderline intelligence (Hassiotis

*et al*, 2008). Those with borderline intellectual functioning do not have an intellectual disability in the strict diagnostic sense (Langdon *et al*, 2010). However, some people within this IQ range may have other developmental disabilities (e.g. ASD, other genetic disorders) that result in significant impairments of social and adaptive functioning. It has been recommended that patients with borderline intellectual disability (e.g. IQ 70–75) can be classified as having a mental disorder as defined in the Mental Health Act (amended in 2007), particularly if they have additional disabilities such as severe social deficits, genetic abnormalities, autism, cerebral palsy and brain injury. Forensic services for people with intellectual disability may have specialist skills in treating those with borderline intellectual disability because of psychological therapies available for people with reduced cognitive abilities. The needs of individuals with borderline intellectual disability who have offended can remain largely similar to those who have mild intellectual disability. Many forensic intellectual disability services admit people with borderline intellectual disability and even low average IQ. However, this service provision is patchy. Halstead (1996) noted that, 'forensic intellectual disability practice quickly reveals the phenomenon of the person who fits so many borderlines that no service is willing to take them on'. Specialist forensic facilities are required for persons with mild and borderline intellectual disability and serious offending behaviour to ensure an adequate period of specialist assessment and treatment. Historically, prison and probation services explicitly excluded men with a full-scale IQ <80 from offence-specific treatment (Langdon, 2010). Therefore there was a cohort of men with 'borderline' intellectual disability who did not receive treatment. Many studies from forensic intellectual disability services also include people with borderline intellectual disability and low average IQ (Torr, 2008). Generally, no distinction is made between the intellectual disability and borderline intellectual disability groups.

It is generally accepted that approximately 2% of the UK general population have intellectual disability (Loucks, 2007), and about 17% will have an IQ <85. The rate of social and intellectual impairments rises considerably among offenders. If both intellectual disability and learning difficulties are considered together, about 20–30% will fall into that category (Talbot, 2008a). These individuals are likely to struggle with standard methods of communication and are likely to require considerable additional support if they are to safely and effectively negotiate the various elements of the criminal justice system.

People with specific learning difficulties as opposed to intellectual disability therefore represent a significantly larger and more functionally able group of patients than are typically cared for in conventional intellectual disability services, and they may feel that services lack the specialist resources to meet their complex needs. Similarly, mental health services are frequently restricted to the care of individuals with severe mental illness and this leaves many individuals with learning difficulties outside conventional statutory support services.

## OFFENDING BEHAVIOUR

The term offending behaviour is problematic when used in relation to people with intellectual disability. Under English law (England and Wales), a crime is defined by two components: *actus reus* (the act of crime) and



*mens rea* (the intent to commit that crime). The latter is difficult to elicit in people with intellectual disability (especially in those with moderate to profound intellectual disability) and is a key issue when it comes to legal perception of the difference between challenging behaviour and criminal behaviour. Similarly, these factors influence police decisions to caution or to arrest and convict an individual with intellectual disability. Thus when a person has moderate to severe intellectual disability, unless the criminal act is very serious, they are unlikely to be dealt with through the criminal justice system. However, the issue becomes far less clear for those with mild intellectual disability where both their understanding of the offence and the appropriateness of them being dealt with through either the health or criminal justice system requires specialist evaluation.

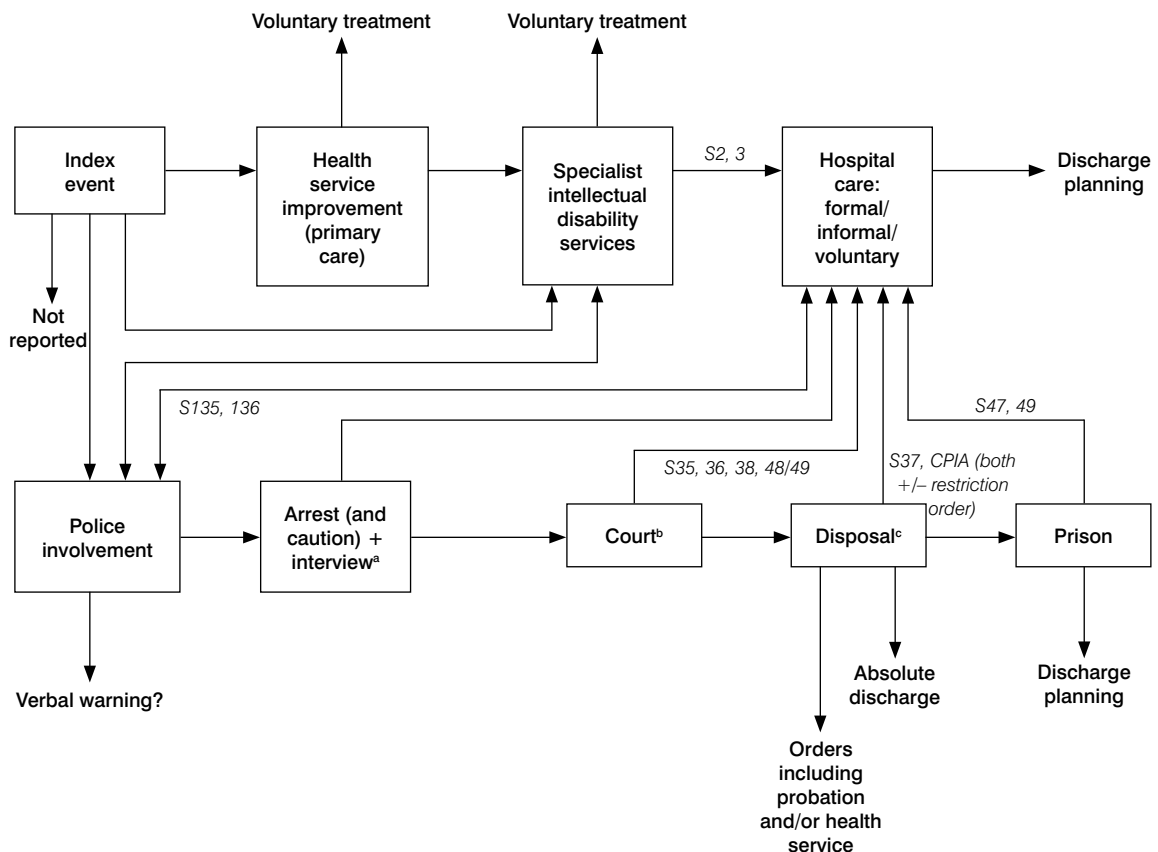
Some believe that the involvement of the criminal justice system in cases of offending by people with intellectual disability is punitive and draconian. A review by McBrien & Murphy (2006) identified that some carers stated that they would not even report serious crimes such as rape if committed by a person with intellectual disability. It may be argued that a failure to report, and therefore to prosecute, episodes of serious challenging behaviour may lead to an individual believing that such behaviour is acceptable, leading to further and potentially more serious acts (Murphy & Mason, 2007). Moreover, the Crown Prosecution Service's decision to prosecute depends on the perceived likelihood of conviction and the extent to which this course of action is considered to be in the public interest (Holland *et al*, 2002). On the other hand, the assumption that forensic psychiatry services offer the way forward for everyone with intellectual disability and offending behaviour could be potentially reductionist and simplistic (B. Fitzgerald, personal communication, 2012).

There has been a general shift from custodial sentencing to an approach to rehabilitate offenders with intellectual disability either in hospital or in community settings. This in turn has an effect on prevalence studies of offending in this population as these are usually conducted in prisons or secure hospital settings where there would inevitably be an overrepresentation of people with intellectual disability who are more able (with mild/borderline levels of intelligence) and who have committed serious offences necessitating remand to prison or secure hospital settings.

Many specialist intellectual disability services in the community have developed extensive 'challenging behaviour' resources, within which significant behaviour which might otherwise be deemed a criminal offence is likely to be dealt with either through use of the Mental Health Act or outside statutory frameworks. Whether these patients access services through forensic services or through 'non-forensic' community and hospital services, the most important factor is that their needs are identified in a timely manner and that they receive the appropriate therapeutic input.

# Care pathway for offenders with intellectual disability

The journey of an offender (without intellectual disability) from index offence through the various stages of the criminal justice system process, including arrest, charging, conviction and potentially custodial sentence, may appear relatively straightforward. However, for a person with intellectual disability this can represent a bewildering sequence of events, as shown in Fig. 1.



**Fig. 1** Pathway of an offender with intellectual disability through the criminal justice system. S, Section (of the Mental Health Act 1983).

a. Appropriate adult (Police and Criminal Evidence Act 1984).

b. Special measures (Youth Justice and Criminal Evidence Act 1999).

c. Criminal Procedure (Insanity) Act 1964, Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (CPIA).

Home Office policy, as far back as 1990 (Home Office, 1990), stated that wherever possible, mentally disordered offenders should receive care and treatment from health and social services rather than be dealt with via the criminal justice system.

The Reed report (Department of Health & Home Office, 1992) in turn called for 'closer working between the Police, Health and Social Services to avoid unnecessary prosecution of mentally disordered offenders', and it set clear principles of care for people with intellectual disability who offend. It advocates a tailored approach to the individual, with care and treatment provided in the community, close to home and support networks.

These principles were supported by the Bradley report (Department of Health, 2009a), which recommends early identification of people with intellectual disability when they come into contact with the criminal justice system, clear referral protocols, appropriate training for those working within the criminal justice system and appropriate community-based treatment and care packages for those at risk. If criminal justice professionals are unaware that the person has intellectual disability or lack knowledge of the support needs of this population and the statutory safeguards which should be available to protect them, then there is a likelihood of significant disadvantage and potential miscarriage of justice (Loucks, 2007; Talbot, 2007, 2008a). Similar problems exist for people with a variety of difficulties, including dyslexia, dyspraxia, speech, language and communication problems, sensory impairments, ADHD and ASD.

In his review (Department of Health, 2009a), Lord Bradley notes that different agencies had very different views of diversion and what it meant. In recognising a range of options on the appropriate interpretation, he attempted to reach a consensus which strikes a balance between the rights of the offender, the rights of any victim and the protection of the public. He described diversion as:

'a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence.' (p. 16)

He also commented on how policy in these areas had developed in a piecemeal fashion, with many governmental departments, agencies and organisations 'working independently of one another, developing policies and practice in isolation, addressing one problem or are part of the system at a time' (p. 123). In other words, 'working in silos'. Lord Bradley recognised that robust governmental arrangements at a national, regional and local level were the key to implementation of effective change and made national accountability a key recommendation of his report.

## SYSTEM RESPONSE TO OFFENDERS WITH INTELLECTUAL DISABILITY

In the past decade, the criminal justice system has made significant efforts to identify individuals with intellectual disability in the system, understand the needs of these individuals and develop care pathways that facilitate the diversion of these individuals into systems of care that are more suitable and appropriate.

## NO ONE KNOWS

The *No One Knows* programme was undertaken by the Prison Reform Trust to address concerns raised by prison staff, prisoners and their families regarding the unmet needs of people with intellectual disability and learning difficulties within the wider interface of prisons, the criminal justice system, specialist health and social services. The review (Talbot, 2008a) found that decision-making by the police on enforcement, diversion and disposal for people with intellectual disability is inconsistent. The use of appropriate adults during police interviews is patchy because the need is not identified or because there are not enough individuals to perform this role. People with intellectual disability and their carers are often baffled by court proceedings, which are rarely adapted to enable them to participate appropriately (Talbot, 2008a). It was apparent that there was lack of adequate staff skills to identify intellectual disability and even if they did, a perverse disincentive to do so as this would bring statutory responsibilities which staff felt unable to fulfil (Loucks, 2007; Talbot, 2007, 2008a). There is a scarcity of adapted treatment programmes for people with intellectual disability in prison, which has been raised as a human rights issue (Joint Committee on Human Rights, 2008).

## LACK OF JOINED-UP WORKING BETWEEN CRIMINAL AND INTELLECTUAL DISABILITY SERVICES

The problem is that there is no joined-up approach between the criminal justice system and health and social care systems in dealing with these issues, and even the effectiveness and quality of court diversion schemes vary in different regions. Awareness among police forces and prison officers across the UK is crucial for this pathway to be efficient, effective and useful for people with intellectual disability. Unfortunately, despite good local initiatives, most regions do not have a training programme in place for all staff concerned, and support for training and liaison work through the commissioning route is at times missing. When compared with the reasonably well-established networks between specialist forensic mental health services and various elements of the criminal justice system, collaborative working between intellectual disability and criminal justice professionals is typically piecemeal or absent. They often appear unaware of each other's roles, responsibilities or potential collaborative solutions to address potentially offending behaviour by people with intellectual disability. Even when individual professionals from the relevant services are working together to establish an effective outcome in an individual case, this is rarely generalised across services. There is clearly a need for a more open debate on this interface between services and a greater commitment to collaborative working (Department of Health, 2009a; Jones & Talbot, 2010). Some people with mild intellectual disability state that they would prefer a fixed prison sentence than the uncertain and potentially far longer detention under a section of the Mental Health Act. This situation has been complicated further by the introduction of the indeterminate prison sentence for 'public protection' (Prison Reform Trust, 2007).

## OFFENDING PATHWAY

The offending pathway will often be cyclical rather than linear. That is, many individuals who have already passed through the criminal justice system will reoffend unless their patterns of offending behaviour are addressed. Unfortunately, few of the programmes designed to address recidivism within prison or probation services are modified to make them accessible for people with intellectual disability (Talbot, 2007). In contrast, individuals with intellectual disability who enter the health system are more likely to access input from specialist services designed to address recidivism.

Although the UK has a long history of specialised service provision for people with intellectual disability and mental health problems, over recent years the political emphasis has been very much on people with intellectual disability accessing 'mainstream' services – i.e. those set up for people with 'normal' intelligence, albeit with some input from professionals in intellectual disability (Department of Health, 2009b; National Institute for Health and Clinical Excellence, 2009). However, in relation to the treatment of recidivism in those with intellectual disability, the benefit of separate specialist services appears to continue to exist.

This creates an interesting dynamic for offenders with intellectual disability treated in specialist forensic intellectual disability units, who often have a mild intellectual disability or an IQ score in the borderline range of intellectual functioning. They often fall between the boundaries of 'mainstream' mental health and intellectual disability services in the community – too disabled for one and too able for the other.

Discussing this issue in the context of offenders with intellectual disability and personality disorder, Alexander *et al* (2010) suggest that although being admitted to mainstream units may achieve the aim of equity of access, achievement is meaningless in the absence of equity of outcome. A low IQ may often exclude people from treatment programmes (Beech *et al*, 1998; Talbot, 2007; Tyrer *et al*, 2007). This happens not necessarily because these mainstream units are overcome by prejudice, but because the treatment content needs to be delivered for people with intellectual disability in a way that is appropriate for their developmental and intellectual level. Economies of scale, as well as availability of a critical mass of expertise may mean that these developmental-level-specific treatment programmes are best delivered in specialised intellectual disability units (Alexander *et al*, 2010).

However, these in-patients will be able to make effective transition to the community only if relevant expertise and resources exist within intellectual disability services. It has been consistently found that this is a group who even after discharge from hospital will need high levels of continuing professional input for many years (Naik *et al*, 2002; Alexander *et al*, 2006).

The following chapters will outline in detail the pathway followed by an offender with intellectual disability through the criminal justice system, health and social care settings.

## RECOMMENDATIONS

- 1 There should be national standards on health and social care provision for offenders with intellectual disability, with clear lines of

- accountability and explicit mechanisms for addressing any apparent gaps in service provision. Particular attention should be paid to the commissioning of a range of in-patient and community services that will allow people with intellectual disability who offend to be managed safely in the least restrictive setting.
- 2 There also needs to be greater clarity in the use of terminology (e.g. intellectual or learning disability, learning difficulties) both within and between health and criminal justice services.
  - 3 Local multi-agency strategic planning groups must be established between intellectual disability and criminal justice services, with the aim of preventing offending and reoffending. These do not necessarily need to be distinct from existing mental health arrangements, but must include specific arrangements for joint training and collaborative working in relation to people with intellectual disability.
  - 4 Psychiatrists in the field of intellectual disability need to be competent in the relevant mental health legislation and know how to apply it when faced with offending behaviour. In addition, a detailed knowledge of relevant mental health, criminal and equality legislation and an understanding of their potential application in proceedings throughout the various stages of the offender's journey is required.
  - 5 Forensic psychiatrists need to have a good understanding of the needs of patients with intellectual disability and learning difficulties, and of the role and structure of specialist intellectual disability services.

# The criminal justice system

## POLICE

Contact with the criminal justice system can be both daunting and confusing. This is magnified when a person has an intellectual disability. People with intellectual disability can come into contact with the police either following behaviour that concerns the public or an alleged offence. If arrested following an alleged offence, issues such as whether the person is fit to be detained or interviewed need to be considered.

People with intellectual disability can vary widely as to their level of functioning and ability, which can further complicate things. They may have little long-term perspective and limited ability to understand the consequences of their actions. They may be easily manipulated. They often make no attempt to disguise what they have done. In trying hard to please authority figures, they may confess to what they have *not* done and may show evidence of increased acquiescence (Finlay & Lyons, 2002).

## SCREENING FOR INTELLECTUAL DISABILITY AND MENTAL DISORDERS

All people in police custody need to be assessed in order to determine whether they are likely to present any particular risks either to themselves or other people. This role is undertaken by the custody officer. Research has raised concerns about the screening processes used in police custody to detect people who may have a psychiatric or medical problem. It is suggested that some people with intellectual disability are not being detected (McKinnon & Grubin, 2010).

Screening should include questions to establish the presence of intellectual disability and, if used consistently, will help to ensure that individuals with health needs are identified early and receive the help which they require (Jacobson, 2008; Talbot, 2008a). The Grubin screening tool (Grubin *et al*, 2002) used in prisons may identify some people with intellectual disability and mental health problems. More recently, the Learning Disability Screening Questionnaire (LDSQ; [www.gcmrecords.co.uk/gcm\\_records\\_007.htm](http://www.gcmrecords.co.uk/gcm_records_007.htm)) has been suggested as being suitable. It should be noted that such instruments can be over-inclusive, and can also identify people who do not have intellectual disability. It is therefore essential that such tools are not the sole sources of indication of any intellectual disability and are followed up with in-depth assessments.

It is important to note that many people with intellectual disability, particularly those who come into contact with the criminal justice system, may have additional mental health problems including other developmental

disabilities, mental illnesses (e.g. psychosis, personality disorder) and substance use disorders (Alexander *et al*, 2011). When a person in police custody appears to have a mental disorder or looks like they need clinical attention, then appropriate help must be sought as soon as possible.

The police surgeon (who is also known as the forensic medical examiner or forensic physician) is asked to assess the detainee in this situation. It is usually the police surgeon who assesses whether the detainee is 'fit to be interviewed', although sometimes psychiatrists can be asked to provide an opinion. It is also known that 'upon this assessment (of whether someone is fit to be interviewed) may hinge the decision of the court to convict the guilty or acquit the innocent' (Rix, 1997).

### *APPROPRIATE ADULT*

In England and Wales, the Police and Criminal Evidence Act 1984 helps to provide special protection to people at police stations who could have a mental disorder or are mentally vulnerable. This is partly done by ensuring that they have an appropriate adult with them while they are in police custody (Perks, 2010), and it is important to do this as soon as possible (Association of Chief Police Officers, 2012). An appropriate adult is required, as detainees 'may need the support of an adult presence; of someone to befriend, advise and assist them to make their decisions' (The Royal Commission on Criminal Procedure, 1981). Research has shown that the number of instances of police requesting an appropriate adult was much less compared with when the researchers felt that this should have occurred (Hodgson, 1997). To ensure continuity, the appropriate adult appointed at the time of the initial interview should follow the person throughout their entire contact with the criminal justice system. The importance of the detainee knowing the appropriate adult and being able to trust them has previously been emphasised by people with intellectual disability (Leggett *et al*, 2007).

### *SECTION 136 AND PEOPLE WITH INTELLECTUAL DISABILITY*

In England and Wales, people with intellectual disability can also come into contact with the police if they are detained under Section 136 of the Mental Health Act (removal of a person with a mental disorder in immediate need of care or control found in a public place to a place of safety) for a mental health assessment. On assessment, some professionals can sometimes express the view that nothing can be done under mental health legislation because the person is not 'mentally ill'. This is especially the case when the assessing professionals do not have expertise or experience in working with people who have intellectual disability. It is important to note that intellectual disability associated with abnormally aggressive or seriously irresponsible behaviour could potentially be a mental disorder warranting treatment under the Mental Health Act, even if the person does not have a mental illness. In addition, many people with intellectual disability, particularly those who come into contact with the criminal justice system, may indeed have mental health problems – including other developmental disabilities, substance misuse, personality disorders – and this complexity highlights the importance of a careful mental health assessment and, if necessary, referral for admission to hospital.



To ensure good continuity of care, it is important to nurture good links between the police and the local community mental health, intellectual disability and hospital services. As part of this, it is important that psychiatric trainees have the opportunity to attend police stations and undertake psychiatric assessments on detainees when these are required. Research has shown that certain routes of referrals are underused, such as from the criminal justice system into community intellectual disability teams (Wheeler *et al*, 2009). A police liaison group could also help with this and should be in place in order to provide a forum where overlapping issues involving both services can be discussed. To encourage good links between the services, there should be a named officer at every police station who works with the local health services.

It is crucial that police officers have received the necessary awareness training so that they can detect individuals who may have a mental disorder or who are mentally vulnerable and know who to contact in order that the individual receives the support and treatment which they require. Forensic liaison services need to be aware of the issues of intellectual disability and the criminal justice system.

## RECOMMENDATIONS

- 1 All police officers, in particular custody officers and community support officers, need to have intellectual disability awareness training as part of their induction process. This training should be provided with input from health professionals.
- 2 Custody suite staff need to be able to recognise whether someone has intellectual disability and know who to contact about this to ensure the person receives the necessary support.
- 3 Appropriate adults should follow the same individual throughout their contact with the criminal justice system to ensure continuity for the detainee.
- 4 There needs to be an identified link police officer at every police station. They should attend the police liaison group which occurs with local health services, and work collaboratively with local mental health and intellectual disability services. Good links with the local community support team must be available, so that they can access advice, assessment, treatment, court reports, and jointly work for individuals in their services, and also more general advice and training in intellectual disability.
- 5 People with intellectual disability should have equitable legal and civil rights, just as people without intellectual disability do. Those who are at risk of offending should also have a right to be held accountable for intentional actions, to have fair boundaries set and to have the full range of sentencing options available to them, if convicted. In view of their vulnerability and limited understanding, they may have difficulty in exercising their rights within the criminal justice system. Consequently, they may need support when they enter the system.

## COURTS AND COURT DIVERSIONS

A court appearance, be it in the lower or higher courts, is a daunting experience at the best of times for most people. An offender or suspected offender with any degree of intellectual disability may be further disadvantaged as a result of their cognitive deficits and life experience. In England and Wales this has been recognised by the criminal justice system in The Criminal Procedure (Amendment No. 2) Rules 2013, which set out provisions for those people classified as 'vulnerable defendants'. This group includes people with intellectual disability.

The Consolidated Criminal Practice Direction states that all possible steps should be taken to assist a vulnerable defendant to understand and participate in court proceedings and that the court process should be adapted as far as necessary (para. 3D.2). These adaptations include the defendant having a chance to visit the court room out of hours to familiarise themselves with the environment, having the proceedings and possible outcomes explained in advance in understandable language, being free to sit with family or a supporting adult during the proceedings, having frequent breaks to aid concentration and having the trial (including cross-examination) conducted in simple, clear language. There is also provision for evidence to be given by video link and for restrictions on who can be in attendance in the court room.

### *EARLY RECOGNITION OF INTELLECTUAL DISABILITY*

For these provisions to have any effect, it is vital that defendants with intellectual disability are recognised as such early on in the process. Court diversion schemes play an important role in the recognition of mental disorder in defendants but there is often little expertise in intellectual disability in these teams. Nacro (2005) noted that most diversion schemes were focused on offenders with mental illness and that there were only three such schemes in England and Wales that had either intellectual disability practitioners or links with intellectual disability services. This is despite the recommendations of the Reed report (Department of Health & Home Office, 1992) that 'court diversion and assessment schemes should develop effective links with local intellectual disability teams, and where possible, team members should be encouraged to contribute to teams' (p. 52, para. 11.120). Not all the courts in England and Wales are served by a diversion scheme and many of these schemes only work a limited number of days per week.

The Bradley report (Department of Health, 2009a) recognised the difficulties inherent in the diversion schemes and the problems resulting from the non-recognition of intellectual disability at the court stage. It was recognised that the most likely people to have contact with individuals with intellectual disability were professionals working in the criminal justice system, and recommended that the probation service and the judiciary should receive mental health and intellectual disability awareness training.

The Department of Health (2010) has produced a booklet aimed at professionals working in the criminal justice system that highlights the needs of people with intellectual disability. The booklet contains a section for court professionals and includes advice on communication and rights and responsibilities when dealing with people with intellectual disability.

Non-recognition of intellectual disability at the early court stage can have an adverse effect on a number of issues including the failure to assess fitness to plead, the failure to make the necessary adjustment to the process, the failure to consider alternative sentencing options and the failure to use the provisions of mental health legislation appropriately if this is applicable; for example, in England and Wales the use of Sections 35 and 36 of the Mental Health Act for assessment/treatment as an alternative to remand in prison or the use of Section 37 hospital or guardianship orders as a means of disposal.

## *PSYCHIATRIC REPORTS*

A further area of concern highlighted in the Bradley report was the difficulties courts faced in obtaining timely and good-quality psychiatric reports (Department of Health, 2009a). It was noted that the courts rely on a limited number of psychiatrists who are willing to undertake such work outside of their NHS duties. There are only a limited number of intellectual disability psychiatrists who have experience in forensic psychiatry across England and Wales, compounding the problem in this particular area. This situation may be further worsened by the ruling that expert witnesses will no longer be immune from suit (*Jones v. Kaney [2011]*). Assessment of people with intellectual disability by practitioners with little or no experience of working with this group can lead to problems with diagnosis or assessment of fitness to plead and there may be confusion about how the Mental Health Act applies to them. Conversely, generic intellectual disability psychiatrists may feel that they do not possess the necessary skills to undertake forensic assessments.

## *WITNESS INTERMEDIARY SCHEME*

The Witness Intermediary Scheme was introduced in 2004 to help vulnerable witnesses to give evidence. The Witness Intermediary Scheme national matching service can be accessed by contacting SOCA (Serious Organised Crime Agency) and aims to match vulnerable witnesses to a suitable professional in their area. These registered intermediaries are professionals from different backgrounds, all of whom have experience in working with people with communication difficulties and have received specialist training from the Ministry of Justice to work in this area. The police and Crown Prosecution Service are able to draw on this resource to aid a vulnerable witness through the criminal justice process. The Coroners and Justice Act 2009 opened the scheme up to vulnerable defendants; however, this section of the Act has not yet been implemented.

## *NECESSARY CHANGES*

For the current situation to improve, it will be necessary to ensure that trainee psychiatrists in intellectual disability psychiatry gain competencies in working within the forensic arena, particularly in regard to understanding court processes, the range of offending behaviour present in this population, the out-patient and in-patient treatment options available and how to assess offenders, particularly with reference to fitness to plead and for recommending appropriate disposal options. Consideration should also be

given to what competencies a forensic psychiatry trainee should have in this area given that general forensic psychiatrists are often the first contact that offenders with intellectual disability have with psychiatric services.

Court diversion schemes need to improve their links with local professionals working with people with intellectual disability. A formal link and service-level agreement would allow for rapid assessment of the offender and timely advice to the court as to who to approach for a formal opinion on crucial issues such as assessment of fitness to plead, what adaptations to the normal court process would be necessary, suitable disposal options and other related issues. A further potential benefit from those local links could be the provision of experienced staff to support those going through the court process.

## RECOMMENDATIONS

- 1 All courts should have access to a court diversion scheme and all such schemes should have input from health professionals trained to work with people with intellectual disability.
- 2 Members of the judiciary and the probation service should be trained in mental health and intellectual disability awareness.
- 3 Psychiatric reports for the courts on people with intellectual disability should be provided by professionals who are both experienced in working with this group and appropriately trained to provide advice to the courts.
- 4 Psychiatric trainees gaining a specialist qualification in intellectual disability psychiatry should be competent in applying those parts of the relevant mental health legislation relating to this population and should be competent in preparing a psychiatric report for the court, particularly in the areas of fitness to plead and appropriate disposal options (how the court deals with the case).
- 5 Psychiatric trainees gaining a specialist qualification in intellectual disability psychiatry should be fully aware of the provisions of the criminal justice system for vulnerable defendants, including knowledge of appropriate disposal options if found guilty.
- 6 Psychiatric trainees gaining a specialist qualification in forensic psychiatry should ideally have gained some experience in working with offenders with intellectual disability and competencies should be identified in regard to this.
- 7 Psychiatric reports for the court on people with intellectual disability should routinely contain recommendations to the court on necessary adaptations to the court process.

## PRISONS

Much has been written about mental health morbidity in prisons both nationally (e.g. Singleton *et al*, 1998) and internationally (e.g. Fazel & Danesh, 2002), and in the past few decades this has contributed greatly to a better understanding of the needs of the prison population.

In England and Wales, following a series of documents in the late 1990s in which existing prison healthcare services were criticised, mental health in-reach teams were commissioned. The idea was that they would function like community mental health teams inside prisons, with the understanding that the prison was part of the community. Since then, more has been learned about the nature of prison mental health in-reach teams and prison healthcare wings (e.g. Forrester *et al*, 2010).

However, there is still a limited understanding of the prevalence and needs of individuals with intellectual disability (defined as significant impairment of intellectual functioning and adaptive behaviour originating before the age of 18) or of the larger group referred to as having learning difficulties (Talbot, 2008a). A range of developmental conditions such as ADHD and ASD as well as individuals functioning within the borderline range of intellectual functioning is often considered along with this group.

In one of the largest studies of its kind, looking at 10 prison surveys across 4 countries involving almost 12000 inmates, Fazel *et al* (2008) found substantial heterogeneity and did not undertake a summary estimate of prevalence. The results suggested that typically 0.5–1.5% of prisoners were diagnosed with intellectual disability (range 0 to 2.8% across studies).

In the UK, figures from *No One Knows* (Talbot, 2008a) suggest that assuming a prison population of 82000, there will be around 5740 people with an IQ <70 and about 20500 with an IQ 71–80. Elsewhere, it has been suggested that up to 11% of remand and 5–7% of sentenced prisoners have intellectual disability, although there appears to be a problem identifying this group because of insufficient screening (Singleton *et al*, 1998). It is therefore thought that people with intellectual disability probably receive insufficient support and treatment presently, although they are known to present with multiple comorbid problems (including physical problems, autism, ADHD and substance misuse) more often than the general population.

When compared with controls within the prison population, individuals with intellectual disability/learning difficulties were, before arrest, more likely to have been homeless, to have had contact with formal support agencies, to have attended a special school which they are less likely to have enjoyed and from which they were more likely to have both played truant and been excluded. They were also more likely to have been 'looked after' in childhood, to have been employed and to have lived with a partner or children (Talbot, 2008b). The information on schooling is particularly poignant and one can only reflect that for many, patterns of maladaptive behaviour – which are deeply ingrained by the time they enter adult services – may have been amenable to more intensive interventions in childhood. Here, the paucity of specialist child and adolescent mental health services for young people with intellectual disability may be particularly relevant.

Petersilia (1997) has commented that those with intellectual disability are likely to experience greater difficulty coping in prison custody and to be vulnerable to bullying, and there are likely to be issues in respect of prison treatment programmes, court attendance and parole hearings. He also noted that people with intellectual disability are more likely to respond to bullying with physical aggression, which could result in transfer to more restrictive secure settings (S. Cooray, personal communication, 2012).

Conventional offending behaviour programmes are not generally accessible for those with an IQ <80 (Talbot, 2008a), as they are deemed ineligible for such programmes and this is especially problematic for people who are serving an Indeterminate Sentence for Public Protection (IPP).

## RECOMMENDATIONS

- 1 Based on existing Department of Health work, all prisons in England and Wales should include proper and full reception screening for intellectual disability as part of routine screening procedures (currently done in accordance with the Grubin tool; Grubin *et al*, 2002). As mentioned in this chapter, the LDSQ can be a suitable tool ([www.gcmrecords.co.uk/gcm\\_records\\_007.htm](http://www.gcmrecords.co.uk/gcm_records_007.htm)).
- 2 All prison healthcare providers should work with local community intellectual disability service providers to assist in ensuring that local team expertise is incorporated within the prison. This could, for example, involve visiting sessions from an intellectual disability/dually trained psychiatrist or regular attendance by a community psychiatric nurse who has training in intellectual disability.
- 3 For such services to work, they will require full integration with existing prison mental health services (including primary care services) to ensure joint working, learning from experience and education.
- 4 Intellectual disability referral pathways need to be clearly mapped in agreement with local intellectual disability services, with the following questions in mind, and recognising that most individuals can be supported within the prison system:
  - a Who should be referred?
  - b When should they be referred?
  - c What response can be expected following referral?
- 5 Local initiatives in respect of joint working with other agencies (including the voluntary service) should be considered and encouraged. Commissioners of services should be integral to this process.
- 6 Inside prisons, joint working between existing mental health providers, primary care and other multi-agency partners is recommended. This may require a joint vehicle for the discussion of complex cases, and the development of a meeting to determine which agencies should be involved in each particular case is recommended. This meeting will resemble an 'internal' MAPPAs meeting, but, unlike MAPPAs, will not be restricted to high-risk individuals.

# Community disposals and hospital treatment

## COMMUNITY DISPOSALS

The Reed report (Department of Health & Home Office, 1992) set clear principles of care for people with intellectual disability who offend. It advocates a tailored approach to the individual, with care and treatment provided in the community, close to home and support networks rather than in hospital settings. This is supported by the Bradley report (Department of Health, 2009a), which recommends early identification of people with intellectual disability when they come into contact with the criminal justice system, clear referral protocols, appropriate training for those working within the criminal justice system and appropriate community-based treatment and care packages for those at risk. The report states that 'community sentences can provide safe and positive opportunities for offenders with mental health problems or learning disabilities to progress with their lives, as well as receiving a proportionate sanction from the court' (p. 91). This move to increasing use of community disposals is also advocated in the White Paper *Breaking the Cycle* (Ministry of Justice, 2010).

There is of course a balance to be struck between public interests of diverting those with significant mental health problems and intellectual disability from the criminal justice system and those factors favouring prosecution and safeguarding the public. The approach to sentencing in England and Wales is set out in *R v. Birch [1990]* (Fig. 2(a)).

For offenders with comorbid mental disorder and intellectual disability, there are a number of factors that would determine whether a community disposal is appropriate. These would not only include the nature of the offence, history of offending, the presence of mental illness, comorbid substance misuse, capacity to consent and the need for public protection, but also issues of vulnerability in prison settings and the availability of adapted treatment programmes.

At the time of sentencing, there are a number of disposals currently available (Fig. 2(b)). Some of these options may overlap for those individuals with intellectual disability who are found unfit to plead and it is established that they did the act or made the omission charged against them (Fig. 2(c)).

If found unfit to plead, an individual with intellectual disability (in England and Wales) can be treated in the community via a guardianship order or a supervision and treatment order. A guardianship order can help in establishing boundaries and can include a requirement for the person to allow access to professionals and to attend for specific activities such as medical treatment, and in the right case can prevent more restrictive options being used. However, guardianship does not provide legal authority

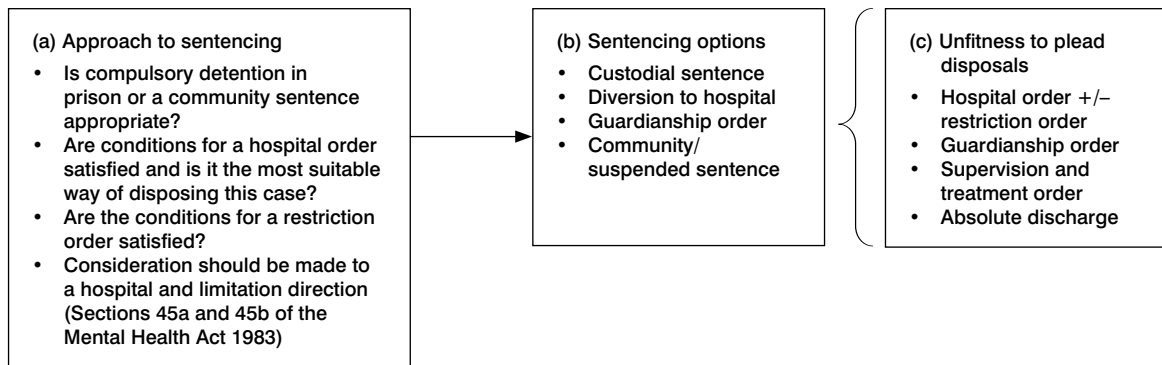


Fig. 2 Sentencing in England and Wales.

to detain a person physically in accommodation or to remove them against their wishes, and should never be used solely for the purposes of transferring any unwilling person into residential care. Nor does it allow for force to be used to secure attendance at specified places for medical treatment to be administered without the person's consent. Even if granted an absolute discharge, it is recommended that appropriate follow-up by specialist services is organised with use of the care programme approach structure.

For offenders with intellectual disability, if they are able to consent, the Criminal Justice Act 2003 introduced a community order/suspended sentence order, with 12 different requirements that an offender can be ordered to complete – see Table 1.

*A Missed Opportunity?* (Khanom *et al*, 2009) advocates increased and more creative use of the community order with greater use of the Mental Health Treatment Requirement (MHTR) option. To facilitate this, practical guidance should be available on how to construct and manage MHTRs for those with intellectual disability. In England, general practice consortia should commission services to enable courts to use MHTRs via interagency protocols.

Recommendations for community disposals require early identification of those offenders with intellectual disability and professionals with the appropriate expertise to assess these individuals and make recommendations for treatment. Screening tools and suggested assessment formats are discussed here and in 'The criminal justice system'.

Services responsible for treatment provision need to be identified early to ensure the legal process is not unnecessarily delayed. Within community settings, this can be provided by community intellectual disability teams, community forensic teams, community mental health teams or specialist forensic intellectual disability teams (very rare in the country). This will depend on availability of services as well as the unique needs of the individual.

The model of a community forensic intellectual disability team is available in Birmingham, Avon and Somerset (Benton & Roy, 2008; Dinani *et al*, 2010), and Leicester operates a virtual community forensic intellectual disability team within a tiered model of service provision (Devapriam & Alexander, 2012). These teams assess individuals who fall in the range of intellectual disability or are eligible for input from intellectual disability services. They provide points of contact at all stages of the criminal justice



**Table 1 Criminal Justice Act 2003 requirements for offenders with intellectual disability**

<b>Requirements for community orders</b>	<b>Level of seriousness</b>	<b>Length</b>	<b>Main purpose(s)</b>
Unpaid work	Low	40–80 h	Punishment Reparation Rehabilitation
	Medium	80–150 h	
	High	150–300 h	
Supervision	Low	Up to 12 months	Rehabilitation
	Medium	12–18 months	
	High	12–36 months	
Programme (accredited)	Medium High	Stated number (or range) of sessions	Rehabilitation
Drug rehabilitation (offender must consent)	Low	6 months	Rehabilitation
	Medium	6–12 months	
	High	12–36 months	
Alcohol treatment (offender must consent)	Low	6 months	Rehabilitation
	Medium	6–12 months	
	High	12–36 months	
Mental health treatment (offender must consent)	Medium High	Up to 36 months	Rehabilitation
Residence	Medium High	Up to 36 months	Rehabilitation Protection
Specified activity	Medium	20–30 days	Rehabilitation Reparation
	High	Up to 60 days	
Prohibited activity	Low	Up to 24/36 months for suspended sentence order/ community order	Punishment Protection
	Medium		
	High		
Exclusion	Low	Up to 2 months	Punishment Protection
	Medium	Up to 6 months	
	High	Up to 12 months	
Curfew (typically up to 12h a day)	Low	Up to 2 months	Punishment Protection
	Medium	2–3 months	
	High	4–6 months	
Attendance centre	Low	12–36 h	Punishment

process, allowing for those never known to services being identified as well as providing nurses trained in the area of intellectual disability to participate in local court diversion schemes. They provide specialist treatment packages and where appropriate liaise with other mainstream mental health services. It is noted that there is a huge unmet need for those falling just outside the eligibility criteria for intellectual disability services but have similar support and treatment needs. Data from these areas suggest that community forensic intellectual disability services can manage risk and provide a good-quality service at a reduced cost by averting the need for expensive secure hospital admission often far from the home of the offender. This is also the least restrictive alternative.

The treatment options available for offenders in hospital under the Mental Health Act (England and Wales) are outlined in Table 2. These hospital orders can be to either specialist forensic intellectual disability hospitals or in some cases mainstream forensic psychiatry facilities.

**Table 2 Treatment options for offenders under the Mental Health Act 1983**

<b>Section</b>	<b>Function</b>
Section 35	The accused is remanded to hospital for a psychiatric report. Evidence from one doctor is required. The order is for 28 days and renewable up to a maximum of 12 weeks.
Section 36	The accused is remanded to hospital for psychiatric treatment. Evidence is required from two doctors. The order is for 28 days and renewable up to a maximum of 12 weeks.
Section 38	Interim hospital order. Evidence is required from two doctors. The order is for 12 weeks and renewable up to a maximum of 12 months. Applies to offenders already convicted.
Section 37	Hospital order following conviction. Evidence required from two doctors. The order is for 6 months and renewable for 6 months, yearly thereafter.
Section 37/41	Hospital order with restrictions. This is issued when there are concerns around public protection. Evidence from two doctors required, with oral evidence from one doctor.
Section 45a	Hospital and limitation directions allow the Crown Court to authorise the detention of offenders in hospital for treatment at the same time as passing a prison sentence. Evidence is required from two doctors.

## RECOMMENDATIONS

- 1 Court and probation staff need to have intellectual disability awareness training as recommended in the Bradley report to allow early identification of offenders with intellectual disability.
- 2 Courts, probation services and youth offending teams in each locality should have access to intellectual disability services as a first point of contact. This should ideally be a dedicated community forensic intellectual disability team or a specialist function within the intellectual disability team. If that is not available, the function can be carried out by a community intellectual disability team. Depending on local protocols, this function may also be carried out by mainstream mental health or forensic mental health teams, provided they have the appropriate skills.
- 3 Protocols for joint working between community forensic intellectual disability, community intellectual disability, community forensic and community mental health teams should be developed locally and opportunities for pooling resources/sharing skills should be explored. Local pathways should be developed in conjunction with other agencies involved in the management of an offender with intellectual disability.
- 4 Community intellectual disability teams should receive further training to manage less serious offending and to provide input where specific community forensic intellectual disability teams are not feasible or where the case-load demands it. Likewise, in areas where they carry out this function, community forensic and mental health services will need training on issues of intellectual disability.
- 5 Training members of the intellectual disability team could include input from psychiatry, nursing and psychology, with the team accepting referrals from existing NHS services and the criminal justice system. The team should provide expertise to the criminal justice system and make recommendations for community disposals where appropriate.

- 6 In order to recommend community disposals, the appropriate treatments should be available (from community forensic intellectual disability teams or from specialists within generic intellectual disability teams) in the form of adapted programmes for substance misuse, sex offender treatment, fire-setting and violent offending, preferably in collaboration with mainstream services as outlined in *Valuing People* (Department of Health, 2001). Such programmes may need to be flexible so as not to exclude those with borderline intellectual disability.
- 7 Higher trainees in both forensic psychiatry and psychiatry of intellectual disability should obtain experience of both specialties with basic competencies described. The training needs of other disciplines in this field should also be considered, especially when plans are in place to adapt existing teams.
- 8 Commissioners of services should be integral to the process of purchasing appropriate services.

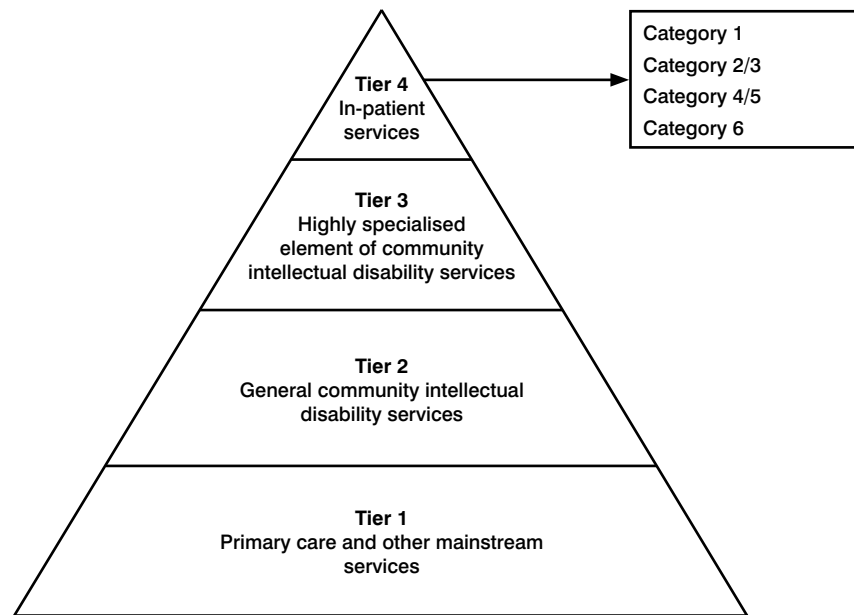
## HOSPITAL TREATMENT

There have been specialist secure beds for people with intellectual disability from as far back as 1920 when Rampton Hospital became the state institution for 'defectives'.

Currently in the UK, there are forensic intellectual disability hospital beds at three levels of security – high, medium and low. Reliable information about the number of these beds and the occupancy rates was lacking, although some projections could be made using data from the *Count Me In* census (Care Quality Commission, 2005) and the Ministry of Justice data on restricted patients (Ministry of Justice, 2009). In addition, there is also an unknown number of locked units – mental impairment units, locked rehabilitation units and step-down units – that are not formally classified as low secure units. There are few services specifically for women offenders with intellectual disability, although high secure hospitals have always operated strict segregation policies, where women make up about 10% of the population (Beber & Boer, 2004). This group of patients have high levels of mental illness, are more likely to have suffered from sexual abuse, and may be more challenging to manage.

An earlier survey of forensic intellectual disability beds estimated that there were 48 high, 414 medium and 1356 low secure beds for people with intellectual disability in 2009 within the 10 strategic health authority regions of England (Alexander *et al*, 2011). In a recent report, the Royal College of Psychiatrists identified six categories of in-patient beds within a four-tiered model of service provision (Royal College of Psychiatrists, 2013) (Fig. 3 and Box 1). Within this categorisation there were 2393 category 1 beds (made up of 48 high, 604 medium and 1741 low secure beds) and 345 category 4 (forensic rehabilitation) beds.

Both these surveys showed a very uneven distribution of beds, with some regions not having any medium or low secure units within their borders. It is this uneven distribution that has led to some offenders with intellectual disability often being placed in units far away from their families because suitable local units are not available (Yacoub *et al*, 2008). On the other hand, some authors (Barron *et al*, 2004) have discussed the economies of scale and commented about how it is unrealistic to have very specialised



**Tier 1** encompasses primary care and other mainstream services. It is the tier of service provision that serves the general health, social care and educational needs of people with intellectual disability and their families. The community intellectual disabilities team and the psychiatrist have limited direct clinical contact in this tier. Nevertheless, they are involved in activities which may influence patients' care and interacting with this tier is essential to the training of intellectual disability psychiatrists.

**Tier 2** is general community intellectual disability services. At this level the person with intellectual disability starts to use specialist intellectual disability services. Most specialist services are provided jointly between health and social services or are moving towards such a model.

**Tier 3** is a highly specialised element of community intellectual disability service. This includes areas of specialised needs such as epilepsy, dementia, challenging behaviour, pervasive developmental disorders and out-patient forensic services.

**Tier 4** is specialist in-patient services. It includes all specialist in-patient services for people with intellectual disabilities, ranging from local assessment and treatment services to high secure forensic services.

**Fig. 3** Tiered/stepped model of care for intellectual disability services (adapted from Royal College of Psychiatrists, 2011).

**BOX 1 CATEGORIES OF IN-PATIENT BEDS WITHIN TIER 4 FOR PEOPLE WITH INTELLECTUAL DISABILITY AND MENTAL HEALTH AND/OR SEVERE BEHAVIOURAL PROBLEMS**

- Category 1: high, medium and low secure forensic beds
- Category 2: acute admission beds within specialised intellectual disability units
- Category 3: acute admission beds within generic mental health settings
- Category 4: forensic rehabilitation beds
- Category 5: complex continuing care and rehabilitation beds
- Category 6: other beds including those for specialist neuropsychiatric conditions

For definitions and illustrative case examples, please refer to Royal College of Psychiatrists (2013).

services of this nature in every district. On balance, it is fair to expect that offenders with intellectual disability should be treated as near as possible to their home area.

Patients referred or admitted to these units have a high rate of psychiatric and developmental morbidity. Most have histories of early deprivation and abuse, about half have personality disorder, the same proportion have substance misuse, a third have mental illnesses and about a third to a quarter have ASD (Alexander *et al*, 2003; Hogue *et al*, 2006). They also have extensive histories of offending behaviour, with risk profiles that are as serious as in those detained in generic forensic units (Hogue *et al*, 2006).

Based on the available bed numbers in 2009, the cost of this provision was estimated at £258–323 million per year, and for an area with spending at this level, there was a surprising paucity of outcome studies (Alexander *et al*, 2011). Over the past 30 years, there were a total of two outcome studies from low, four from medium and two from high secure hospitals in this category (Day, 1988; Butwell *et al*, 2000; Halstead *et al*, 2001; Reed *et al*, 2004; Alexander *et al*, 2006; Gray *et al*, 2007; Morrissey *et al*, 2007; Alexander *et al*, 2011). The most common outcome variable described was duration of stay. Others included direction of care pathway, institutional aggression, reoffending, reconviction and readmission to hospital. None of the outcome studies have looked at the cost of placements and this means that discourse about costs in this area is often based on anecdote and opinion rather than objective evidence.

Likewise, the nature of treatments has not been described in any detail except in a couple of studies (Day, 1988; Alexander *et al*, 2011) and this ties in with the view that intervention and care packages are still relatively non-specific and unfocused (Barron *et al*, 2004). The four-stage model proposed by Johnston (2008) that includes assessment and motivational work, interventions including foundation treatments, offence-specific treatments and personality disorder symptom reduction treatments, consolidation or relapse prevention, and discharge, offers a broad framework that can be used to describe the nature of interventions.

A number of studies have, however, described in detail the process and outcome of specific psychological, offence-focused therapies such as anger (Taylor & Novaco, 2005) and sexual offending (Lindsay, 2005; Large & Thomas, 2011).

Based on a review of outcome literature, the report *People with Intellectual Disability and Mental Health, Behavioural or Forensic Problems* (Royal College of Psychiatrists, 2013) sets out a minimum data-set of outcome variables divided into the categories of measures of treatment effectiveness, patient safety and patient experience (Table 3).

## RECOMMENDATIONS

- 1 Particular attention should be paid to the commissioning of a range of in-patient and community services that will allow these patients to be managed safely in the least restrictive setting. Offenders with intellectual disability should be treated as near as possible to their home area.
- 2 Reliable data on the number of offenders with intellectual disability in secure units should continue to be actively collected.

- 3 The nature of treatments offered should be clearly described and a common data-set of short-term and long-term outcome variables collected through a nationwide audit. This should include information about the cost of placements. Such information should be used to identify predictors of length of hospital stay and successful treatment outcomes.

**Table 3 Minimum data-set of outcome variables for in-patient beds in categories 1 and 4**

Measures at baseline	
Essential	<ul style="list-style-type: none"> <li>▪ Diagnoses on ICD-10 criteria or equivalent: include degree of intellectual disability, pervasive developmental and other developmental disorders, personality disorders, mental illnesses, substance misuse or dependence and physical disorders (Gray <i>et al</i>, 2007; Alexander <i>et al</i>, 2011)</li> <li>▪ IQ score on WAIS-IV or equivalent (Wechsler, 2008)</li> <li>▪ Coded forensic history: index offence, nature of detention, past convictions for offences of violence, sex, arson and other offences, history of aggression towards other people, property and self (Alexander <i>et al</i>, 2006, 2011; Gray <i>et al</i>, 2007)</li> <li>▪ HoNOS secure score (Dickens <i>et al</i>, 2007)</li> </ul>
Desirable	<ul style="list-style-type: none"> <li>▪ PCL:SV score (Hart <i>et al</i>, 1995; Morrissey, 2003, 2007, 2011; Gray <i>et al</i>, 2007; Fitzgerald <i>et al</i>, 2011)</li> <li>▪ HCR-20 (Webster <i>et al</i>, 1995; Gray <i>et al</i>, 2007; Fitzgerald <i>et al</i>, 2011)</li> <li>▪ VRAG score (Gray <i>et al</i>, 2007; Quinsey <i>et al</i>, 2006; Fitzgerald <i>et al</i>, 2011)</li> <li>▪ START score (Webster <i>et al</i>, 2004)</li> </ul>
Measures of effectiveness	
Essential	<ul style="list-style-type: none"> <li>▪ Global measures or measures of symptom severity: HoNOS secure, yearly and at discharge (Dickens <i>et al</i>, 2007)</li> <li>▪ Progress measures: community leave status (no leave/escorted leave/unescorted leave)</li> <li>▪ Progress measures: length of stay</li> <li>▪ Progress measures: direction of care pathway (whether moved to a less restrictive setting)</li> </ul>
Desirable	<ul style="list-style-type: none"> <li>▪ Symptom-specific assessment scales (e.g. measures of anger, depression/anxiety, other psychopathology)</li> <li>▪ HCR-20: yearly and at discharge</li> <li>▪ START score: regular intervals (e.g. 2-monthly and at discharge)</li> <li>▪ CGI scale (Guy, 1976)</li> </ul>
Measures of patient safety	
Essential	<ul style="list-style-type: none"> <li>▪ Proxy measures of aggression: index of the number of restraints and seclusions (total number divided by length of stay) (Alexander <i>et al</i>, 2010)</li> <li>▪ Proxy measures of self-injury/self-harm: index of the number of incidents (total number divided by length of stay)</li> <li>▪ Number of alerts regarding patient safety</li> <li>▪ Any 'never' incidents: escapes, suicide</li> </ul>
Measures of patient experience	
Essential	<ul style="list-style-type: none"> <li>▪ Evidence of patient participation in treatment planning: My Shared Pathway (NHS Networks; Esan <i>et al</i>, 2012)</li> <li>▪ Patient satisfaction surveys</li> <li>▪ Evidence of carer/family participation in treatment</li> </ul>
Desirable	<ul style="list-style-type: none"> <li>▪ Measures of social climate: Essen Climate Evaluation Schema or equivalent (Schalast <i>et al</i>, 2008)</li> <li>▪ Quality of Life measure: EQ-5D-3L or equivalent, yearly and at discharge (EuroQol Group, 1990)</li> </ul>

CGI, Clinical Global Impression scale; HoNOS, Health of the Nation Outcome Scales; HCR-20, Historical, Clinical, Risk Management-20; ICD-10, *International Classification of Diseases (10th edn)*; PCL:SV, Psychopathy Checklist: Screening Version; START, Short-Term Assessment of Risk and Treatability; VRAG, Violence Risk Appraisal Guide; WAIS-IV, Wechsler Adult Intelligent Scale, Fourth Edition.

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